STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING _____ B. WING _____	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 7/26/13. Event ID# NYQX11.	F 000	Croasdaile Village acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of Quality of Care of residents. The Plan of Correction is submitted as a written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the July 26, 2013 survey. Croasdaile Village's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Croasdaile Village reserves the right to refute any deficiency on this Statement of deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	#1 Upon entrance of the survey team on 7/22/13, daily staffing form reflected staffing information from 7/19/2013. According to regulation F-356, staffing information must be updated daily and posted in public view for anyone to review. Upon knowledge of the incorrect date, Administrator directed Scheduler to update staffing form for correct day. Staffing form was updated prior to the survey team leaving the building on 7/22/13.	07/22/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rebecca E. Marion | LNHA | 8-16-2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING _____ B. WING _____	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post daily nurse staffing in the facility. Findings included: On 7/22/2013 at 4:35 PM, the daily nurse staffing form was observed hung on the bulletin board beside the 2 south nursing station. The staffing posted was for the date 7/19/2013. On 7/22/2013 at 4:39 PM, the daily nurse staffing form was observed hung on a bulletin board inside the enclosed 2 north nursing station. The staffing posted was for the date 7/19/2013. In an interview with the facility administrator on 7/22/2013 at 5:00 PM, the administrator reported the expectation was nurse staffing should be posted every day.	F 356	#2 Administrator educated Scheduler on 7/22/13 on the regulations related to the posting of daily staffing. Staffing form was updated. After the exit conference on 7/26/13, Administrator held another meeting with Scheduler reviewing the survey week and reiterating the importance of updating the daily staffing form. On 8/16/13, Administrator and DON presented expectations for staffing posting to the Scheduler for accountability. (See Attachment #1) #3 The Quality Assurance Chairperson or designee will conduct weekly audits (See attachment #2) at all nursing units to ensure that the staffing sheet is posted, updated, and contains information including but not limited to (See Attachment #3): • Facility name • Current date • Total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: o Registered nurses o Licensed practical nurses of licensed vocational nurses (as defined under State law). o Certified nurse aides • Resident census.	07/22/2013 07/26/2013 08/16/2013 08/16//2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING _____ B. WING _____	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post daily nurse staffing in the facility. Findings included: On 7/22/2013 at 4:35 PM, the daily nurse staffing form was observed hung on the bulletin board beside the 2 south nursing station. The staffing posted was for the date 7/19/2013. On 7/22/2013 at 4:39 PM, the daily nurse staffing form was observed hung on a bulletin board inside the enclosed 2 north nursing station. The staffing posted was for the date 7/19/2013. In an interview with the facility administrator on 7/22/2013 at 5:00 PM, the administrator reported the expectation was nurse staffing should be posted every day.	F 356	Weekday and Weekend staffing schedules will be monitored by Administrator and Director of Nursing, or designee and follow up actions implemented to ensure that staffing information sheet is current and accurate. #4 Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II construction, two story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K 072 **Corrective Action:** Maintenance Department contracted with Croasdaile's licensed electrician to install single outlets behind locked doors E-109, E-171, E-209, and E-272. All mechanical lift chargers will now Be housed inside these rooms. Rooms are locked and will be under the Supervision of the nursing team.	09/04/2013
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 8/14/13 at approximately noon the following obstruction to means of egress was observed as non-compliant, specific findings include; batteries to equipment were being recharged in the corridor at 1 sourth east, near E176 Exit without visible supervision or enclosed within a storage room.	K 072	**Identifying Life Safety Issue:** The Plant Operation Director and Healthcare Administrator will Complete audit to ensure that Corrective action is in place and functioning properly. **Systematic Changes:** Maintenance Technician will Utilize Preventative Maintenance Software to generate monthly Audit Checks to ensure	09/05/2013 09/04/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Healthcare Administrator — 08/28/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II construction, two story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Corrective Action is in compliance. (Attachment #1 &#2). Completed work orders will be submitted to Healthcare Administrator monthly for review. **Monitored:** Plant Operations Director and Healthcare Administrator will Audit Compliance weekly during rounds. Monthly PM orders will be submitted To the Quality Assurance and Performance Improvement Committee For review. QAPI committee will has the right to discontinue the audits once the committee determines compliance has been achieved.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 8/14/13 at approximately noon the following obstruction to means of egress was observed as non-compliant, specific findings include; batteries to equipment were being recharged in the corridor at 1 sourth east, near E176 Exit without visible supervision or enclosed within a storage room.	K 072		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Healthcare Administrator — 08/28/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.